CareSource™
P.O. Box 8738
Dayton, OH 45401-8738

Pharmacy Prior Authorization Request Form

PHARMACY FAX # 866-930-0019

Note: Prior Authorization Requests without medical justification or previous medications listed will be considered INCOMPLETE; illegible or incomplete forms will be returned.

PATIENT INFORMATION

Patient Name		Date
CareSource ID	DOB	Gender: M/F
Medication Allergies		
Pharmacy	Pharmacy Phone	

PROVIDER INFORMATION

Prescriber Name	NPI #	DEA #
Prescriber Specialty	Prescriber Address	
Office Fax	Phone	Office Contact Name

MEDICATION REQUESTED

Drug Name	Strength	Directions (Sig)	
Duration of Therapy: Days: _____ Months: _____	Quantity	HBAIC w/Date (if applicable)	Diagnosis
Is the Patient currently treated on this medication? ☐ Yes; Date Started mm/dd/yy _____/_____/_____ ☐ No			

MEDICAL JUSTIFICATION: Include Other Relevant Medications Tried and Results

Please indicate previous treatment and outcomes below					
Previous Medication	**Strength**	**Qty**	**Directions (Sig)**	**Dates (mmddyy to mmddyy)**	**Reason for Discontinuation**
1					
2					
3					
4					
5					

RELEVANT MEDICAL RATIONALE FOR REQUEST/ADDITIONAL CLINICAL INFORMATION (Attach Relevant Lab Results and Chart Notes)*

Provider Signature	Date

In order to process this request, please complete all boxes completely.

CareSource will review and issue a decision within 24 hours of the original receipt of a pharmacy prior authorization request if received by 5:00pm on Friday with the exception of weekends and CareSource designated holidays.